NC Rural Health Research & Policy Analysis Center

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Profile of Rural Health Clinics: Clinic & Medicare Patient Characteristics

Review of 2009 Medicare Outpatient Claims Data

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OVERVIEW

In 1977, Public Law 95-210 created the Rural Health Clinic (RHC) Medicare and Medicaid reimbursement designation for qualified primary care practices. With over 3,900 certified sites located across the county, RHCs are an important component of the rural health care infrastructure.[1] RHCs can be private/for-profit or non-profit. Some operate as independent medical practices, while others are part of a hospital-owned system or other health care organization ("provider based"). RHCs receive cost-based reimbursement, subject to tests of reasonableness, for primary care services provided to Medicare beneficiaries.

This Findings Brief is the second in a series on RHCs which draws on a large, national secondary dataset that includes data on all RHCs that bill Medicare.[2] Using data extracted from 2009 Medicare outpatient provider claims, this Findings Brief presents a summary of the geographic distribution and clinic-level characteristics of RHCs, as well as an overview of the Medicare beneficiaries they served.

KEY FINDINGS

- RHCs billing Medicare in 2009 were almost evenly divided between independent RHCs (1,799) and provider-based RHCs (1,695).
- In 2009, the average independent RHC treated 547 Medicare beneficiaries and filed 2,481 claims. The average provider-based RHC of a hospital with 49 or fewer beds saw 520 beneficiaries and had 2,215 claims, as compared to 531 beneficiaries and 2,113 claims for clinics of hospitals with 50 or more beds. Although number of patients and total charges were not statistically different by RHC type, independent RHCs had more claims and received lower payments per claim than provider-based RHCs.
- Median RHC visits per Medicare beneficiary seen was 3.0 (mean = 4.8) in 2009.
- The median distance an RHC's Medicare patient traveled one-way (beneficiary address ZIP centroid to RHC ZIP centroid) was 6.2 miles. Medicare patients seen at RHCs in the Mountain (12.5 miles) and Pacific (7.0 miles) Census Divisions had the longest median travel distance.
- Medicare patients seen at RHCs in 2009 were primarily female (58%) and white (91%).

DATA SOURCE AND METHODS

The study included all RHC Medicare claims filed in 2009. Medicare RHC claims data were obtained through an agreement between the Federal Office of Rural Health Policy and the Centers for Medicare and Medicaid Services (CMS). RHCs were classified as independent or provider-based according to their Medicare Provider Number (last 4 digits identify facility type).[3] Provider-based RHCs not subject to the upper limit on their cost-based rate per

[1] *CMS Name & Address Listing for RHC Based on Current Survey*, 07/28/2012. Available at www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

[2] Approximately 90% of all RHCs billed Medicare for RHC services in 2009.

[3] There were 2 home health agency (HHA) and 17 nursing home (NH) provider-based RHCs who billed Medicare for RHC services in 2009 (1% of all provider-based RHCs); for analysis purposes the 2 HHA provider-based RHCs and 8 of the NH provider-based RHCs are included in the PB≤ 49 beds category and the remainder in ≥50 beds.

visit (uncapped) were identified as those clinics with a parent hospital reporting 49 beds or less according to CMS' Online Survey, Certification, and Reporting (OSCAR) Provider of Services system data base. [4] Medicare beneficiary data was taken from the Denominator File which is populated from the CMS Enrollment Data Base. Distance values were calculated at the clinic level for each RHC's cohort of Medicare patients using OSCAR data to identify the RHC ZIP code and computing one-way distance by road miles from claims (beneficiaries) address ZIP centroid to RHC ZIP centroid.

GEOGRAPHIC DISTRIBUTION

The 2009 Medicare outpatient provider claims include over 8.1 million claims filed by 3,494 RHCs in 45 states. The numbers of RHCs by type that billed Medicare in 2009 are listed by state in Table 1.

Table 1: RHCs Billing Medicare in 2009 by State

		Provider-Based					Provider-Based		
State	**Indpt**	**≥50 beds**	**≤49 beds**	**Total**	**State**	**Indpt**	**≥50 beds**	**≤49 beds**	**Total**
AK				0	MT	8		38	46
AL	38	10	10	58	NC	59	12	9	80
AR	33	18	20	71	ND	18		42	60
AZ	3		12	15	NE	32	8	86	126
CA	124	44	73	241	NH	4	1	8	13
CO	16	3	22	41	NJ				0
CT				0	NM	3		7	10
DE				0	NV			8	8
FL	68	5	16	89	NY	7			7
GA	34	13	25	72	OH	7			7
HI			2	2	OK	21	7	12	40
IA	61	12	75	148	OR	40		17	57
ID	20	3	22	45	PA	37	6	14	57
IL	135	10	56	201	RI				0
IN	48	8	4	60	SC	67	7	11	85
KS	62	7	101	170	SD	25		33	58
KY	93	11	24	128	TN	41	1	6	48
LA	47	13	39	99	TX	136	37	121	294
MA	1			1	UT	8	1	7	16
MD				0	VA	32	4	8	44
ME	10		27	37	VT	5		10	15
MI	67	45	39	151	WA	59	6	55	120
MN	25	8	43	76	WI	20	2	28	50
MO	175	82	79	336	WV	30	14	7	51
MS	72	27	45	144	WY	8		9	17
					Total	1,799	425	1,270	3,494

CLINIC CHARACTERISTICS

There are small differences in average charges per claim and average payment per claim across the different RHC types (Table 2). However, both the number of Medicare beneficiaries served and number of Medicare claims filed ranged widely from one clinic to another, irrespective of RHC type (independent or provider-based).

[4] RHCs receive cost-based reimbursement, subject to tests of reasonableness, for core Medicare services. For independent RHCs and provider-based RHCs that are an integrated part of hospitals with 50 beds or more, one test of reasonableness is a cap or upper limit on the rate per visit; in 2009 this cap was $76.84 per visit. Provider-based RHCs of hospitals with 49 beds or less are not subject to the cap.

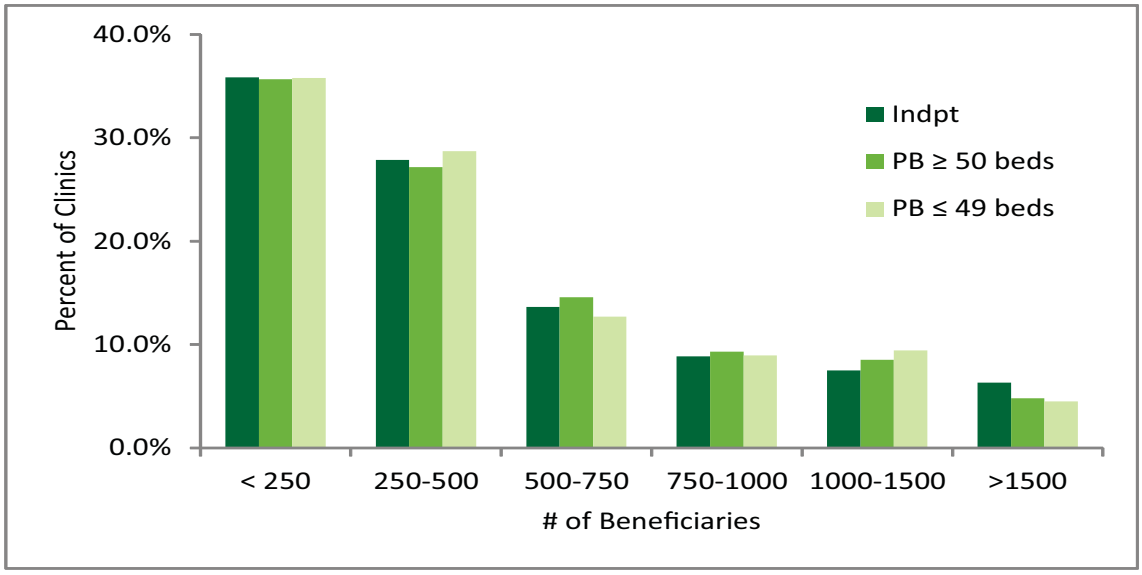
Table 2: 2009 RHC Medicare Beneficiaries, Claims, Charges and Payments per Clinic

				Statistically Significant Differences*		
	Independent	Provider-Based ≥ 50 beds	Provider-Based ≤ 49 beds	Ind v. PB <50	Ind v. PB 50+	PB<50 v. PB50+
Number of Beneficiaries						
Average	547	531	520			
10th & 90th Percentiles	91 - 1,173	94 -1,134	90 - 1,157			
Number of Claims						
Average	2,481	2,113	2,215	YES	YES	
10th & 90th Percentiles	281-5,658	264-4,968	249-5,115	YES	YES	
Total Charges						
Average	$248,414	$238,057	$253,094			
10th & 90th Percentiles	$27,665-$578,859	$27,929-$521,997	$26,133-$561,597			
Charge per Claim						
Average	$101.22	$112.43	$112.57	YES	YES	
10th & 90th Percentiles	$74.12-$136.96	$79.69-$151.42	$77.30-$151.51	YES	YES	
Total Payments						
Average	$194,149	$223,870	$279,907	YES	YES	YES
10th & 90th Percentiles	$21,846-$458,840	$24,106-$504,842	$28,817-$642,959	YES		YES
Payment per Claim [5]						
Average	$80.19	$103.67	$123.16	YES	YES	YES
10th & 90th Percentiles	$72.94-$88.18	$76.21-$146.33	$82.37-$164.63	YES	YES	YES

** Statistically Significant Differences columns test whether two types of RHCs are different in their averages (t-tests) or in their distribution (Mann-Whitney)*

The distribution of the numbers of Medicare beneficiaries served, based on claims filed, varies little by type of RHC but ranges widely from one individual clinic to another. An individual beneficiary may have received care from more than one RHC; the distinct count below is an unduplicated count of Medicare beneficiaries at the individual clinic level.

Figure 1: The number of distinct beneficiaries varies across RHCs, but is similar across RHC types



Note: Distribution is not statistically different by RHC type.

[5] Payment variations amongst RHCs can exist due to differences in cost-based rates for those below the UPL, as well as due to differences in providers' charge structures since patient deductible and co-insurance portions are determined based on actual charges.

PATIENT VISITS & DISTANCE TRAVELED

Of the 45.5 million total Medicare beneficiaries in 2009[6], 1.6 million (3.7%) had at least one visit to an RHC during the year. The median number of RHC visits for these Medicare beneficiaries was 3.0 for the year. Table 3 lists by Census Division the one-way distances traveled by RHCs' cohorts of 2009 Medicare patients. Medicare patients seen by RHCs in the Mountain and Pacific regions had the longest median distances (beneficiary ZIP centroid to RHC ZIP centroid). There were small differences in median distances traveled based on the type of RHC where the Medicare patient was seen: independent, 6.3 miles; provider-based ≤49 beds, 6.3 miles; and provider-based ≥50 beds, 5.8 miles.

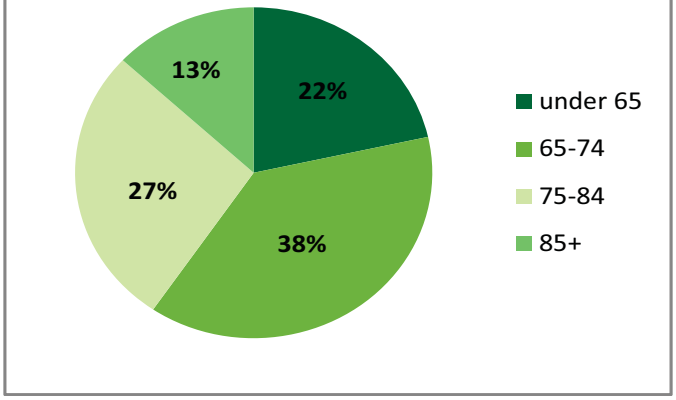
Table 3: One-Way Distance Traveled to an RHC by Medicare Patients in 2009 (Miles)

Census Division	Median	25th Percentile	75th Percentile
Northeast			
New England	6.8	4.1	11.7
Middle Atlantic	5.6	2.9	10.4
South			
South Atlantic	5.9	3.8	11.7
East South Central	5.9	3.7	11.9
West South Central	6.2	4.8	16.6
Midwest			
East North Central	5.5	2.9	11.4
West North Central	5.2	3.8	11.5
West			
Mountain	12.5	9.9	35.4
Pacific	7.0	5.7	11.7
Total	6.2	4.4	13.6

AGE DISTRIBUTION & OTHER CHARACTERISTICS

The average age of an RHC Medicare patient in 2009 was 71 years (median = 72 years). The majority of Medicare beneficiaries seen at an RHC are less than 75 years; however 13% of those seen were 85 years and older (Figure 2). Most RHC Medicare patients were female (58%), and the majority were white (91%). African American beneficiaries comprised 6.6% of RHC Medicare patients.

Figure 2: Age Distribution of RHC Beneficiaries (2009)



CONCLUSION

Rural health clinics are critical pieces of the rural healthcare infrastructure. However, to date there has been little information on the numbers and types of patients seen in these settings and if differences in patient visits vary by RHC type. This lack of basic service data has made it difficult to determine how changes in Medicare and Medicaid policies or implementation of components of the Patient Protection & Affordable Care Act, such as the Medicare Shared Savings Program and Accountable Care Organizations, may affect RHCs.

Because reimbursement policies treat provider-based RHCs associated with hospitals with fewer than 50 beds differently than independent and provider-based associated with hospitals with more than 50 beds, we explored whether systematic differences existed between the types on key variables. Overall, RHCs systematically vary little across type: they have similar numbers of unique Medicare beneficiaries and total Medicare claims. However, independent RHCs have more claims per beneficiary and a lower average payment amount per claim. These differences could result from differences in the patterns of care (eg, "medical home" orientation or type of services) across the clinic types.

Because RHCs bill through a different mechanism than other primary care providers using a limited code set, it is often difficult to integrate them into new reimbursement and/or incentive payment structures or to quantify the impact of their participation. This series of findings briefs will provide a national baseline on RHCs' Medicare billing and reimbursement activity as well as a profile of Medicare beneficiaries served by RHCs.

[6] *Total Number of Medicare Beneficiaries, 2009* available at www.statehealthfacts.org

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